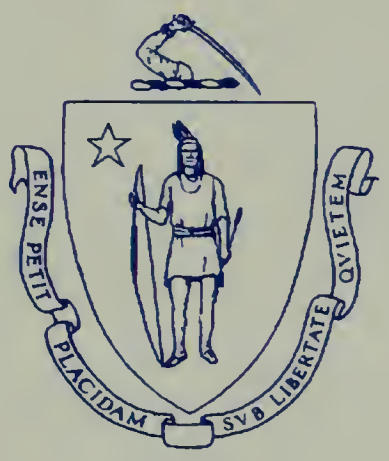
THE ATTORNEY GENERAL'S REPORT ON COMMUNITY BENEFITS BY HEALTH MAINTENANCE ORGANIZATIONS



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Dear Friends and Colleagues:

I am pleased to issue this first status report on the implementation of the Community Benefits Guidelines for Health Maintenance Organizations. These voluntary Guidelines were the product of a cooperative effort by Massachusetts HMOs, health care advocates and the Attorney General's Office, and are modeled after the ground-breaking Community Benefits Guidelines for Nonprofit Acute Care Hospitals. Their purpose is to encourage all HMOs to share responsibility for the health care needs of medically-underserved Massachusetts residents through the development and funding of formal Community Benefits Programs.

All Massachusetts HMOs reported on their Community Benefits Programs for the 1996-1997 reporting year, as called for by the Guidelines. These reports reflect the HMOs' diverse approaches to Community Benefits, as well as their varying stages of Program development. They indicate that Massachusetts HMOs allocated approximately $6.8 million toward Community Benefits during 1996-1997. Of perhaps greater significance than dollars allocated this first year is the progress that many HMOs have made on their efforts to institutionalize their commitment to Community Benefits Programs. These HMOs have laid the foundation for Programs that, if properly implemented and funded, should provide critical health services to Massachusetts communities in future years.

One of my highest priorities as Attorney General has been to preserve and improve access to affordable, quality health care services for all Massachusetts citizens and their families. Massachusetts HMOs deserve recognition for their voluntary efforts to serve the underserved, particularly in light of the increased pressures they are facing in the health-coverage marketplace. I look forward to a continued collaboration with HMOs and health care advocates that will allow us to advance the goals of the HMO Community Benefits Guidelines.

Thank you for your interest and participation.

Sincerely,

Scott Harshbarger

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Executive Summary

In 1996, Attorney General Scott Harshbarger became the first, and only, public official in the nation to issue voluntary Community Benefits Guidelines for Health Maintenance Organizations (the "Guidelines"). The Attorney General, working cooperatively with HMOs and health care advocates, framed this set of Guidelines to encourage HMOs to share responsibility in meeting the health care needs of uninsured, underinsured, vulnerable, and at-risk populations. These Guidelines call for all Massachusetts HMOs to incorporate formal Community Benefits Programs into their institutional missions. The HMO Guidelines followed the Attorney General's ground breaking issuance in 1994 of Community Benefits Guidelines for Nonprofit Acute Care Hospitals, and represent the next step in the evolution of community benefits planning.

This report represents the Attorney General's review and analysis of the first round of Annual Community Benefits Reports filed by HMOs conducting business in Massachusetts for the reporting year of July 1, 1996 to June 30, 1997. Twelve HMOs filed Annual Reports, and a thirteenth HMO filed a letter stating that it was in the middle of a merger with another plan. Therefore, every HMO that currently participates in the Massachusetts market filed some documentation of its Community Benefits activities.

Some of the highlights of the HMOs' first year of Community Benefits Programs are as follows:

- HMOs reported spending a total of $10,014,460 on Community Benefits during the reporting year, including administrative costs. After determining that some of the items claimed as Community Benefits clearly were not within the intent or spirit of the Guidelines, such as Medicaid shortfalls and taxes paid by for-profit HMOs, the Attorney General's Office adjusted this total to $6,775,473.

- The Annual Reports indicate that HMOs are engaging in a wide range of Community Benefits activities, including AIDS prevention projects, free immunizations and health screenings, early childhood intervention efforts, domestic violence awareness initiatives, and women's health forums. A few HMOs are using their expertise as providers of health insurance coverage by offering "dues subsidy plans" that help low-income individuals retain or obtain health insurance coverage.

- HMOs provided information on 514 separate Community Benefits projects or other efforts that existed in either the planning or operational stages during the reporting year. This Report classifies these projects into the following categories: direct care; education; grants, donations and scholarships; health insurance; information access; screening; and volunteerism.

a) The largest category of Community Benefits efforts (approximately 200 in number or 39 percent) fell within the category of grants, donations and scholarships.

(b) The second most frequently-reported category is community education, with 123 projects (around 24 percent) that related primarily to health education.

(c) Seventy-five projects (around 14 percent) consisted of volunteerism efforts. While reportable volunteer efforts were limited to those which had taken place during employee work hours or which were encouraged, organized, or facilitated by the HMOs, some of the Annuals Reports were unclear as to whether their volunteer efforts met this definition.

(d) Fourteen Community Benefits projects (less than 3 percent) provided direct care. A single HMO was responsible for over three-quarters of the projects in this category.

(e) Only seven Community Benefits initiatives (just 1 percent) provided or increased access to health coverage to the uninsured.

- The governing boards of most HMOs have adopted resolutions acknowledging at least a general commitment to the principle of Community Benefits.

- Although there were wide variations among the HMOs, the Program functions that stand out as needing the greatest attention are needs assessment, Program evaluation, and community participation.

- The Guidelines contemplate that HMOs will develop formal processes to assess the unmet health needs of their communities, select populations at which to target initiatives based upon these needs assessments, and develop formal Community Benefits Programs which address the needs of target populations. Many Reports, however, reveal a lack of connection between HMOs' needs assessment results and their choice of target populations, or between their identified target populations and the actual projects that they have chosen to pursue.

- The Guidelines also emphasize the need for ongoing Program evaluation. Few HMOs reported any substantial efforts in this regard.

- Finally, the Guidelines call upon HMOs to create mechanisms for meaningful community participation in the planning and implementation of their Community Benefits Programs. Although several HMOs are demonstrating a commitment to the community participation concept, this is an area of weakness for some HMOs. A strong community participation process is a key element of any

effective Program because it will tend to strengthen every other Program function, and ensure that real Community Benefits are delivered to those who are most in need.

Because these Guidelines represent a novel initiative, we anticipate that both HMO Community Benefits Programs and the corresponding reporting process will be works in progress. For the 1997-1998 reporting year, the primary objectives will be: (1) to further refine the reporting process to make the Annual Reports a more reliable and informative indicator of the HMOs' progress on their Community Benefits Programs; (2) to develop measures to assess the level of the HMOs' financial commitment to their Community Benefits Programs, and the effectiveness of these Programs; (3) to organize a technical support meeting for the Community Benefits coordinators and other HMO leadership to assist them as they move forward on their Programs; and (4) to consider innovative ways in which HMOs can partner with each other and with hospitals and other providers to coordinate delivery of Community Benefits in future years.

The Annual Reports reflect a reasonable first effort by many HMOs to institutionalize the concept of Community Benefits within their organizational structures. The Reports also highlight the diverse approaches and levels of commitment by individual HMOs toward their Community Benefits Programs. This year's most significant achievement might be that some HMOs that previously had no formal, institutionalized commitment to Community Benefits have laid the groundwork for solid Programs. The ultimate success of these Programs will depend on how well the HMOs build on these foundations by following through on the processes that they have established and by committing the financial resources necessary to achieve their stated objectives.

THE ATTORNEY GENERAL'S REPORT ON HMO COMMUNITY BENEFITS PROGRAMS

I. INTRODUCTION

In February 1996, Attorney General Scott Harshbarger issued the nation's first set of Community Benefits Guidelines for Health Maintenance Organizations (the "Guidelines"). The purpose of the Guidelines was to establish and formalize voluntary principles that would encourage both for-profit and non-profit HMOs to continue and enhance their commitment to serving disadvantaged and medically-underserved populations, and to institutionalize the Community Benefits Programs through which they undertake this mission.

This Report contains an analysis of the status of HMO Community Benefits Programs in Massachusetts for the first reporting year of July 1996 through June 1997. It is based upon the information that each Massachusetts HMO submitted in mid-1997 in accordance with the public reporting provision of the Guidelines. These Annual Reports provide information about the various Community Benefits Programs that HMOs have supported during this period. They indicate that HMOs spent an approximate total of $6.8 million on Community Benefits Programs in Massachusetts during the 1996-1997 reporting year.

The Reports also document the HMOs' progress in instituting the internal processes through which they conduct their Community Benefits Programs. These include the processes through which the HMOs obtain community input and conduct needs assessments to identify their communities' unmet health needs, choose the populations at which to target their Programs, and evaluate these Programs over time. Copies of the HMOs' Annual Reports are available for public inspection at the locations listed in Appendix A.

The HMOs' diverse approaches to their Community Benefits Programs are reflected in their Annual Reports. These Reports indicate that some HMOs are providing substantial Community Benefits and that others have laid solid foundations upon which to build their Programs. They also reveal wide variations, however, in the stages of development, levels of commitment and overall quality of the individual HMOs' Community Benefits Programs.

HMO Community Benefits Programs thus remain very much a "work in progress." This conclusion does not come as a surprise given that formal Community Benefits programming is a new endeavor for many HMOs. The focus of the following report will be to identify the strengths and weaknesses of the current Programs, the areas in which the Guidelines and reporting mechanisms themselves could benefit from clarification, and the Attorney General's expectations and goals for the next reporting year.

A. BACKGROUND

The increased dominance of HMOs in the Massachusetts health coverage market (over 2.4 million plan members), as well as the continued growth of the ranks of the uninsured (around 700,000 Massachusetts residents) and others who lack access to affordable, quality health care, are two developments that prompted the Attorney General to propose formal Community Benefits Guidelines for HMOs. Although some HMOs already had been making significant efforts to provide Community Benefits, the Attorney General believed that the increased prominence of HMOs corresponded with a heightened corporate responsibility on the part of all HMOs to contribute on a more formal basis to the health status of the communities that they serve.

Another consideration that led the Attorney General to develop these Guidelines was the existence of hospital-sponsored Community Benefits Programs. Massachusetts hospitals already had formally acknowledged their Community Benefits obligations through their voluntary participation in the 1994 Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals (the "Hospital Guidelines"). The increased role that HMOs are playing in the health care system led the Attorney General to conclude that HMOs should adopt a similar set of voluntary principles, in part to level the playing field between hospitals and HMOs.

The Attorney General developed the HMO Guidelines through an extensive process of consultation and partnership with representatives of the HMO industry and community groups. Many of their comments and perspectives are indeed reflected in the final product. The HMO Guidelines are modeled to a large degree on the Hospital Guidelines, which also broke new ground when the Attorney General issued them in June 1994.

Both the Hospital and the HMO Guidelines represent unique non-regulatory, voluntary approaches that encourage these institutions to respond to the unmet health needs of the communities they serve. Neither set of Guidelines mandates that a Community Benefits Program serve a particular community or dictates that a Program offer certain types of benefits. Both sets of Guidelines do, however, strongly suggest that HMOs focus on the special needs of the poor, the elderly, children, racial, linguistic and ethnic minorities, refugees, immigrants and people with physical and cognitive difficulties. They encourage hospitals and HMOs to tap into their own particular resources and areas of expertise. They recommend that hospitals and HMOs implement a process for community participation to ensure that their Community Benefits Programs address their communities' actual health needs and priorities. They emphasize that hospitals and HMOs should evaluate their Programs periodically to determine their effectiveness. Finally, they call upon hospitals and HMOs to issue yearly public reports on the status of their Programs.

B. ROLE OF THE ATTORNEY GENERAL IN HEALTH CARE

The Attorney General has made the protection of consumer interests in the area of health care one of his highest priorities throughout his administration. During this time, our health care system has undergone a dramatic transformation from which managed care has emerged as our *de facto* national health care policy. This revolution in health care presents new challenges as well as new opportunities for the average consumer who must learn to navigate a new health care maze.

The Community Benefits Guidelines for hospitals and HMOs are two of the many initiatives through which the Attorney General has used the broad public protection powers of his office to assist consumers whose needs are not adequately met by our complex and fragmented health care system. Almost every section of the Attorney General's Office has worked to promote wider access to quality health services. For example, the Attorney General has used his power under state charities laws to develop a national model for community and institutional protections that govern the sale of hospitals and HMOs to for-profit companies with the goal of protecting local communities and ensuring continued access to health care. Last year, the Attorney General issued a comprehensive report on the state of managed care in Massachusetts which called for the creation of a framework of regulatory oversight for managed care organizations to protect consumers. The Attorney General also provides direct assistance to individual consumers who are experiencing difficulties with their Medigap, Medicare, managed care and traditional indemnity insurance coverage through his Regulated Industries Division's insurance hotline.

The Attorney General has worked toward making health care coverage accessible to all Massachusetts consumers. He regularly represents consumers in rate hearings before the Division of Insurance in an effort to keep Medigap rates affordable for elders. The Attorney General also played a key role in securing last year's enactment of two pieces of landmark state legislation: the Improved Access to Health Care bill, that extends health care benefits to low-income children and prescription drug benefits to low-income seniors; and the Affordability and Access to Health Insurance bill that prohibits the medical underwriting and preexisting conditions exclusions through which insurers attempt to avoid extending coverage to sick or high-risk individuals. This represents just a small sample of the Attorney General's work in the area of health care.

C. IMPLEMENTATION OF HMO COMMUNITY BENEFITS GUIDELINES

Since February 1996, when the HMO Guidelines were first issued, the Attorney General's Office, the HMO industry and consumer representatives have devoted substantial efforts toward their effective implementation. The Attorney General's Office has met on several occasions with representatives of individual HMOs and with the Massachusetts Association of HMOs ("MAHMO") for the purpose of clarifying and resolving issues related to the Guidelines. Throughout this period, the Attorney General's Office has responded to numerous inquiries from the individual HMOs' Community Benefits coordinators concerning the development of their Community Benefits Programs and

preparation of their reports. The Attorney General's Office also has met periodically with a Citizens Advisory Board on Community Benefits[1] to discuss developments in the implementation of the Guidelines.

In September 1996, consistent with the terms of the Guidelines, the HMOs filed Interim Reports on their Community Benefits Programs. The Attorney General's Office provided feedback to the individual HMOs and published its own summary and evaluation of the Interim Reports in December 1996. Subsequent to the filing of the Annual Reports, the Attorney General's Office communicated with several HMO's to obtain clarification of some of the reported information. The Attorney General's Office also has initiated preliminary discussions with interested parties regarding fine-tuning of the reporting process for future years.

II. ANALYSIS OF THE HMO ANNUAL REPORTS UNDER THE COMMUNITY BENEFITS GUIDELINES

The primary goal of the Attorney General's Community Benefits Guidelines is to encourage HMOs to develop community benefits that "promote preventive care and to improve the health status and quality of life for working families and populations at risk, whether or not those individuals are currently HMO members." Consistent with this broad public health objective, the Guidelines anticipate that HMOs will seek to address the needs of the "medically underserved" through their Community Benefits Programs.

The intent of the eight delineated Community Benefits Guidelines has been to focus HMOs' efforts on the foregoing principles. These Guidelines also serve as a useful framework for a discussion of how well HMOs have performed in their development and implementation of Community Benefits Programs during the 1996-1997 reporting year. What follows is the Attorney General's Guideline-by-Guideline analysis of the first set of Annual Reports filed by the HMOs. This is a collective analysis of the HMOs' Programs that is not intended to identify or rate the performance of individual HMOs.

A. The governing body of each HMO should adopt and make public a Community Benefits Policy Statement setting forth its commitment to a formal Community Benefits Program.

This first Guideline refers to the establishment of the process through which an HMO recognizes and institutionalizes its commitment to develop a formal program for delivering Community Benefits within the HMO's service area. It involves public acknowledgment, through a resolution of its governing board, of its commitment to Community Benefits and of the value of collaboration with community members.

There was substantial compliance with the key elements of this guideline. Of the twelve HMOs that filed annual reports, all but two clearly had adopted Community Benefits Policy Statements through a board resolution. Half of these Policy Statements reflect at least a general commitment to a formal Community Benefits Program. Of the six that did not make an explicit reference to a formal program in their Policy Statements, it appeared from the balance of their reports that at least two of them do indeed have formal programs.

The better Policy Statements contained more than a general reference to the HMOs' responsibility for Community Benefits. They also noted the importance of community participation in the program development and evaluation process. Some of the weaker Policy Statements were overly vague or failed to acknowledge the HMOs' commitment to Community Benefits Programs that serve individuals not enrolled in the plans.

B. The governing body and senior management of the HMO should be responsible for overseeing the development and implementation of the Community Benefits Program, the resources to be allocated, and the administrative mechanisms for the regular evaluation of the Program.

This Guideline contemplates active participation by the leadership of HMOs to ensure that the plans' Community Benefits Programs receive support on an organizational level. The central roles of an HMO's governing body and senior management are to ensure: (1) that the goals set forth in the plans' Community Benefits Policy Statements are reflected in the actual Programs; (2) that the HMO sets a budget that allocates adequate resources to meet these goals; and (3) that the HMO evaluates its Policy Statements and Programs periodically to determine that they are effective and remain consistent with the plan's strategic vision.

Although this Guideline refers to those who occupy the highest positions within their organizations, it was not meant to imply that they are the only important actors in the Community Benefits process. Rather, it recognizes the responsibility of HMO leadership to promote an institutional acceptance of Community Benefits that extends through every level of the HMO. This includes the development of opportunities for all HMO employees to participate in Community Benefits Programs.

Compliance with this Guideline ranged from excellent to less-than-satisfactory. The reports of approximately half of the HMOs reflect strong performance in this area. These plans have created internal advisory boards or other formal structures to oversee Community Benefits Programs, and often have dedicated an employee to serve as coordinator of the Program. Their reports contain detailed descriptions of the functions of these organizational structures, and specify the roles that senior management and others play within them. The strongest reports contain lists or charts that identify the participants and their roles. They describe the process by which the HMOs inform and include their employees in their Community Benefits Programs, and cite examples of how senior management actively has promoted the Community Benefits concept within their organizations. They also describe the budgeting and resource allocation process for their Community Benefits Programs.

Many of the weaker reports claim that the HMO leadership is involved in Program oversight, but offer little explanation or supporting information that would allow us to evaluate whether these plans have an effective management system in place. In some cases, it appears that senior management or governing boards retain all decision-making powers even though they are far removed from the Programs themselves. In other cases, it is hard to ascertain what, if any, level of involvement senior management has in the Programs, or if any efforts are made to include employees at other levels of the organization. Many of these plans have not created a formal organizational structure for Community Benefits, but have assigned these functions to existing departments that might not be the most appropriate choices to carry out their Community Benefits missions (e.g., public affairs and quality management departments).

We observed weaknesses in most of the HMOs' program evaluation efforts, at least in the way they are reported. Few of the HMO reports touched upon this subject, and most of those did so in a cursory way. One explanation for this deficiency might be a perception on the part of the HMOs that because many of their Community Benefits Programs are still in the early implementation stages there is little to evaluate. It is never too soon, however, to design the administrative mechanisms for ongoing program evaluations that the plans can implement at the appropriate time. It is also necessary for plans to report on all of these efforts.

C. The governing body and senior management of the HMO should seek assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program, and in defining the targeted population and the specific health care needs to be addressed by the Community Benefits Program.

Community input and collaboration are at the heart of the Community Benefits process. The Guidelines recommend that HMOs make efforts to reach out to community groups and representatives, including plan members, particularly to those whose needs historically have been underserved by the health care system. To be effective, a Community Benefits Program must encourage the participation of those who live and work in a particular community and who, therefore, have the most profound understanding of its needs and challenges. A strong community participation process will tend to enhance the other functions of a Community Benefits Program, including needs assessment and program evaluation.

The HMOs' performance in the area of community participation ranged from extremely good to nonexistent. One third of the HMOs made substantial efforts to solicit and obtain community participation. These HMOs provided considerable documentation regarding the groups with which they had established collaborative relationships. They also had created advisory committees, whose members included a significant number of representatives from prominent community groups, to plan and implement their Community Benefits Programs.

Other HMOs did not have comprehensive structures for community participation already in place, but indicated progress in reaching out to community representatives and including them on Community Benefits Committees. Furthermore, at least two HMOs reported that they had established meaningful contacts with communities by serving on the Department of Public Health's local Community Health Network Areas ("CHNAs").

Finally, one third of the plans either demonstrated virtually no effort to obtain community input, or did not include enough detail to allow us to determine whether the reported community input was meaningful. For example, one plan stated that it had solicited participation from "members of the community," but did not elaborate any further.

In addition to community input, the Guidelines recommend that HMOs seek out the participation of their members in their Community Benefits Programs. Most HMOs indicated that they have used a variety of mechanisms to encourage member participation, such as surveys, newsletters, comments cards, and focus groups. HMOs also reported that they had recruited members to serve on the committees responsible for their Community Benefits Programs.

Some HMOs have member-participation mechanisms targeted toward obtaining member input on a broad spectrum of topics. It was not always apparent from those HMOs' Annual Reports whether they used those mechanisms to obtain input specifically on Community Benefits Programs, a fact that they should articulate clearly. Other HMOs acknowledged that the only members who participated in their Community-Benefits planning processes were also employed by those HMOs. This is not consistent with the process that the Guidelines anticipated. Finally, other Reports were unclear as to whether there was any participation by non-employee members.

D. Each HMO should develop its Community Benefits Program based upon an assessment of the health care needs and resources of the identified populations, particularly lower and moderate-income communities. The Program should consider the health care needs of a broad spectrum of age groups and health conditions.

The fourth Guideline calls for HMOs to undertake the following: (1) to conduct formal needs assessment processes to determine the actual health care needs of the communities they serve; (2) to identify the target populations that their Community Benefits Programs will serve, based upon the results of their needs assessments; and (3) to create a formal "Program" through which they deliver benefits designed to address the needs of the selected target populations.

1. Needs Assessments

The Guidelines contemplate that HMOs will review public health data and other indicators of health status and involve community representatives to identify and prioritize the unmet health needs of their communities. The HMOs' attempts to conduct needs assessments, like their efforts to obtain community input, varied from minimal to very comprehensive. Four HMOs conducted reasonably comprehensive needs assessments. These HMOs obtained and analyzed data from a variety of sources, including state and local agencies, the Massachusetts Prevention Centers, community health centers, CHNAs, hospitals, medical schools, and schools of public health. These plans also surveyed community health centers for their needs, and conducted interviews with personnel from the above list of sources. One plan developed a fairly sophisticated demographic analysis for the Boston area, and is planning to conduct door-to-door surveys and focus groups in several Boston housing developments.

Most of the remaining HMOs conducted needs assessments that consisted of contact with a limited number of agencies or other sources for information and direction. One HMO provided funding for the United Way to conduct a needs assessment. A few HMOs did not conduct needs assessments at all, or reported on them in such a vague or perfunctory manner that it was impossible to determine their efficacy.

Some HMOs relied primarily on analyses of member demographics, distributions of surveys to employees and members, and reviews of grant proposals in their needs assessment processes. These are valuable methods for obtaining input. Alone, however, they are not adequate substitutes for either the consideration of public health data, or the meaningful inclusion of community representatives.

There is no reason for any HMO not to excel under the needs assessment Guideline. Relevant public health data is readily available from a number of sources, including hospitals and various government and private entities. These include municipal public health departments, the Division of Health Care Policy and Finance, the Division of Medical Assistance, the Department of Mental Health, the Department of Public Health and its Massachusetts Prevention Centers and CHNAs. The Guidelines specifically promote the use of such existing information to avoid wasteful duplication of effort. Furthermore, several HMOs have developed effective strategies for involving communities in their needs assessment process. In short, needs assessment is an area in which the HMOs could make tremendous improvement with a minimal expenditure of resources.

2. Target Populations

At least two thirds of the plans determined target populations or priorities for their Community Benefits Programs. Of the four ways in which the Guidelines suggest that HMOs might define their target communities (territorially, geographically, demographically or epidemiologically), most HMOs adopted either the demographic or epidemiologic approach. Many HMOs took the lead of the Guidelines, which urged them to pay special attention to certain groups such as children, the elderly, working or low-income populations, and victims of domestic violence.

A few HMOs appear to have selected target populations or priorities either without the use of needs assessments, or in complete disregard of their own needs assessments. For example, one HMO used Department of Public Health data to determine that cancer and heart disease are priority health needs, but then implemented a Community Benefits Program that targeted unrelated needs. Although projects not tied to needs assessment results might yield significant benefits to the community, HMOs should explain any decisions to target unrelated populations. Otherwise, the obvious conclusion will be that their Community Benefits efforts are the result of a haphazard process instead of the formal, well-integrated approach contemplated by the Guidelines.

3. Program Development

The Guidelines contemplate that each HMO should provide Community Benefits through a formal, well-designed Community Benefits Program. There were, however, many "disconnects" between the stated goals of an HMO's Community Benefits Program and the benefits that the HMOs actually provided. In several instances, the actual Community Benefits projects bore no relation to the identified target populations, but appeared instead to have been the result of arbitrary selection. For example, one HMO identified children and seniors as its target populations, but then chose to direct a large share of its Community Benefits resources toward sponsorships of sporting and other civic events. In future years, we would expect to see a closer nexus between the HMOs' identified target populations and the Community Benefits they actually provide. If not, the logical conclusion again will be that the reported benefits are not the product of a coordinated Program to provide Community Benefits.

E. The HMO should develop and market products which would attract all segments of the population.

Because we did not explicitly request that the HMOs document their efforts to develop products for new or diverse populations, only four HMOs reported on this issue. One of these HMOs reported that its central mission is to provide managed care for those individuals facing financial, social and cultural barriers, and that the majority of its members are enrolled through the Medicaid Program. The information contained in the other three reports was quite general.

In future reporting years, we would encourage plans to report on their efforts to develop and market products for diverse populations. This is an opportunity for HMOs to demonstrate how they are dealing with the ever-increasing diversity within their memberships.

F. The HMO should strive to offer and promote, consistent with existing laws and regulations, direct enrollment for non-group coverage and continue to work toward insurance market reform so that managed care will be an option for all working families and individuals.

The purpose of this Guideline is to encourage HMOs to undertake initiatives and to support legislative efforts aimed at improving access to non-group health coverage for those individuals who do not have employer-sponsored or other health coverage. Since the adoption of the Community Benefits Guidelines in 1996, and with the support of the HMO industry, Massachusetts has enacted non-group reform legislation that requires insurers and managed care organizations that participate in the state's small-group market to offer non-group products that meet certain minimum standards and are not medically-underwritten. Several HMOs, along with MAHMO, were actively involved in the legislative process that led to the passage of this new law. Although the non-group law and other recent health care market reform legislation do not solve all of the problems of the uninsured, they are a start in the right direction.

In their Community Benefits Reports, some HMOs note their support for the non-group legislation or their earlier participation in the non-group or small-group markets. To date, nine HMOs have filed non-group health plans for sale under the new law. Although the non-group legislation eliminates statutory health-status related barriers to access, affordability continues to be an issue as the membership fees charged by some HMOs would be out of the reach of many consumers. As discussed below, some plans have used "dues subsidy" programs to help make non-group coverage more available to low to moderate income individuals. The future challenge will be to ensure that individuals who could benefit from non-group coverage are informed of their options, and provided with accurate information when they seek to enroll. HMOs have a key role to play in both regards.

G. The HMOs should take steps to reduce cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.

As minority populations grow at exponential rates in Massachusetts and throughout the United States, the health care industry has an increasing obligation to provide accessible and high quality services to individuals who are from different cultures and possess varied levels of English-speaking ability. Programs and services geared to overcoming language, cultural and physical barriers are essential to the delivery of competent health care to a diverse population.

Some HMOs have begun to meet this challenge, making significant efforts to accommodate the linguistic needs of various groups. Three HMOs documented efforts to compile lists of bilingual employees and providers, translate written materials, and provide interpreters. Four HMOs utilize the AT&T language line to communicate with patients. One HMO made arrangements with a Cambodian social services agency to serve Khmer-speaking members during special monthly clinics.

With respect to issues of access for people with disabilities, two HMOs reported on efforts to make their health centers or provider offices more accessible. One HMO reported providing TTD/TTY access for the hearing impaired.

Because we did not specifically ask the HMOs to report on initiatives to reduce linguistic, cultural and physical barriers, this is another area where many of them provided limited documentation. We are aware that some HMOs have developed significant programs in these areas, and would encourage all HMOs to report this information in future years.

H. The HMOs should strive to help Massachusetts consumers who are about to lose coverage or who are uninsured, to maintain or obtain, as applicable, health care coverage, at least for limited periods of time, at reduced or subsidized rates.

This Guideline recognizes that the lack of affordability of health coverage and health care services leads to high rates of uninsurance and prevents individuals from obtaining preventive and medically-necessary services on a timely basis. It suggests that a central focus of HMO Community Benefits Programs should be on the provision of preventive care

and subsidized coverage for the uninsured who are unable to pay for health care services and coverage.

Several HMOs provided some direct health care services as part of their Community Benefits Programs. These services included, for instance, immunizations (e.g., flu shots) and screenings for various medical conditions (e.g., high blood pressure, cholesterol, diabetes). The nature and scope of the direct health care services reported by the HMOs is discussed below in greater detail.

A far less common Community Benefit offered by the HMOs was direct assistance with the cost of health coverage. Only four HMOs report having programs designed to make their products more affordable and accessible to low-income individuals and families. Participation in most of these programs is limited to those who previously have been full-paying members of the HMO.

It would be impossible to overstate the importance of "dues subsidy" or similar programs in the context of HMO Community Benefits Programs. Any initiative directed at reducing the ranks of the uninsured provides a valuable Community Benefit. HMOs are uniquely situated to operate such programs because, unlike hospitals which are in the business of providing health services, HMOs primarily are in the business of providing health coverage. This, presumably, is what HMOs do best.

The Community Benefits Guidelines emphasize the importance of developing Community Benefits Programs that are consistent with an HMO's strategic vision and particular strengths. The provision of subsidized coverage should be an area of strength for every HMO, and might be the most efficient and effective use of HMO Community Benefits resources. For these reasons, the Attorney General commends those HMOs that have shown leadership in this area, and strongly encourages the development of more of these types of Community Benefits Programs.

I. The HMO should make an Annual Community Benefits Report available upon request to the Public at the HMO and through the headquarters of the Massachusetts Association of HMOs (MAHMO), where the Report will also be available upon request to the public and to the Office of the Attorney General. The Report should describe the HMO's level of community benefits expenditures and describe the HMO's approach to establishing those expenditures.

This Guideline promotes the creation of a public record of the efforts that HMOs are devoting to their Community Benefits Programs. For the first year, the Guideline called for the HMOs to file Interim Reports of their progress by September 30, 1996. For this and all subsequent years, the Guideline calls for the filing of Annual Reports by June 30. The purpose of these filings is to publicize and document the Community Benefits process and achievements, and to provide an opportunity for review and public discussion. The Guideline encourages the HMOs to solicit public comment in response to the Annual Reports as another means of obtaining community input on their Community Benefits Programs.

Response to the report-filing requirements was excellent. Fifteen HMOs filed Interim Reports. This allowed the Attorney General's Office to provide each HMO with comments and guidance that the HMO could consider in its program development and in the preparation of its Annual Report.

Twelve HMOs subsequently filed Annual Reports, all but one on a timely basis. A thirteenth HMO filed a letter in lieu of a complete report, stating that it was in the middle of a merger with another plan. One of the plans that had filed an interim report did not file an Annual Report because it had left the health coverage market during the year. Finally, one other HMO that had filed an interim report subsequently merged with another plan, which filed an Annual Report that included their combined Community Benefits activities. In short, every HMO that currently participates in the Massachusetts market filed some documentation of its Community Benefits activities on or around June 30, 1997.

The quality of the Annual Reports varied. The Attorney General's Office had requested the HMOs to provide concise statements on a wide range of topics, and to avoid submitting superfluous documentation or other information that did not directly address one of the identified topics. We also had asked the HMOs to complete a standardized "grid" (see Appendix B) detailing each of their Community Benefits projects.

The vast majority of the HMOs followed the requested format. Several of the Annual Reports stood out as providing meaningful, substantive information in a concise form. From these, it is possible to determine the quality and scope of their Community Benefits Programs. Other HMO's filed reports that were abbreviated or vague, which made it difficult to draw any reliable conclusions about their commitment to providing Community Benefits.

III. THE HMO COMMUNITY BENEFITS PROGRAMS

A. Expenditures

According to the Annual Reports, HMOs spent a total of $10,014,460 on Community Benefits during the 1996-1997 reporting year. This amount included program costs as well as administrative costs. The Attorney General's Office adjusted this amount downward after determining that some of the items claimed as Community Benefits clearly fell outside of the Guidelines. The adjusted total came to $6,775,473. Of this amount, $5,244,357 was spent on program costs, and $1,531,116 went toward administrative costs.

Two large-ticket items that the Attorney General deducted from the total expenditures reported by the HMOs were amounts spent on taxes by for-profit HMOs, and a shortfall reported by one HMO in connection with its participation in the Medicaid program. Deductions were made as well in cases where HMOs reported expenditures that occurred outside of the twelve-month reporting period.

The Attorney General also excluded HMO expenditures on activities that simply do not fit within even the most expansive definition of Community Benefits as contemplated by the Guidelines. These include sponsorships of dinners and sporting events for medical and certain professional organizations, charitable contributions that have no direct connection either to health care or to any Community Benefits Program operated by the HMO, and certain marketing activities that do not seem likely to provide any real benefit to underserved populations. This is not to suggest that these charitable works are not worthwhile; rather, they simply are not appropriately classified as Community Benefits under the Guidelines. For this first year of the Guidelines, the Attorney General's approach was to accept the HMOs' representations as valid if any reasonable theory could be advanced as to how their projects and expenditures fall within the category of Community Benefits. The Attorney General is working to refine the reporting process and to further define what is a "Community Benefit" under the Guidelines in order to promote consistency and credibility in future reporting years (see below).

The actual levels of spending on Community Benefits covered a wide spectrum, with individual HMOs spending from less than $25,000 to more than $2,500,000. Differences in both the sizes of the HMOs' market shares and the stages of development of their Community Benefits Programs explain some of these variations. An HMO's reported expenditures for this year, however, are not necessarily a meaningful measure of either its commitment to its Community Benefits Program or the Program's overall strength. Although many of the newer Community Benefits Programs do not have major expenditures to report, some seem to be instituting solid structures and processes that indicate great potential. In contrast, some Programs that pre-date the Guidelines are much better funded but lack strong needs assessment or community participation processes.

The ultimate success of any Community Benefits Program will depend in part on the foundations that HMOs lay to achieve institutional acceptance of the Community Benefits concept, obtain community input, and design Community Benefits that address otherwise unmet health needs. It also will depend increasingly on the HMOs' willingness to devote the resources necessary to meet their Program goals. We anticipate that the HMOs will begin to increase their levels of financial commitment to their Community Benefits Programs as these Programs mature. Although it is difficult to judge the total Program expenditures during this start-up year, it is reasonable to anticipate that an industry that provides health coverage to over 2.4 million Massachusetts residents will allocate more than $6.8 million to Community Benefits in future years.[2]

B. Community Benefits Projects

After adjustment, the HMOs provided information on 514 separate Community Benefits projects or other efforts that existed in either the planning or operational stages during 1996-1997. What follows is an analysis of these endeavors by program type: direct care, education, grant-making, health insurance, information access, screening, and volunteerism. Most of the information on which this analysis is based was derived from a "grid" format that the HMOs completed as a component of their Annual Reports (see Appendix B). The purpose of the grid was to encourage plans to provide standardized information about each of their Community Benefits projects on a variety of topics including goals, target populations, numbers of people served, needs assessments, outcomes and costs.

In response to the information contained in the Annual Reports, we have renamed some of the grid's categories to be more descriptive of the actual projects included within them. For example, "grant-making" became "grants, donations and scholarships." Furthermore, it was difficult to determine the most appropriate category for some projects. For the sake of consistency, in a small number of cases we altered an HMO's original designation by reassigning a project to a different category. Pie charts that illustrate the breakdown of Community Benefits projects by (1) type of program and (2) target population served are included in Appendices C and D.

1. Grants, Donations and Scholarships

The most frequently-cited Community Benefits efforts fall within the category of grants, donations and scholarships. Most of these 200 grants (around 39 percent of the total) provide direct funding to community-based programs or to specific target groups.

Some examples of outside programs to which HMOs are lending their financial support are as follows. A North Shore HMO provides funding to health education programs and programs that offer a continuum of health care services to abused women and children. A health insurer serving the greater Boston area funds an ongoing AIDS prevention project that targets diverse populations within the city through the publication of multilingual educational materials and the provision of health care services to women with HIV. The same HMO supports a program that strives to prevent unwanted teen pregnancy and HIV infection.

Another HMO contributes to child development and job training programs for homeless and high-risk families at a Boston family and health services center. That plan also participated in a "Safe Play Initiative" that mobilized community resources to clean and patrol twelve city parks to provide safe, drug-free recreational areas for neighborhood children.

A grant to the city of Springfield from a central Massachusetts HMO provided immunizations to underserved preschool children, reaching 450 uninsured families. To address a high incidence of child abuse in its service area, a New Bedford-area health plan designed a comprehensive child-development program for low-income Spanish-speaking parents.

An HMO that serves Boston's inner city participated in the development of a career project designed to promote interest in the biomedical sciences among minority students. The same health plan funds a teen-empowerment program aimed at violence prevention in the public schools and supports the Big Sister Association in its effort to provide mentors for young women at risk.

To address the epidemic of violence against women, one Boston-area HMO has joined forces with the Elizabeth Stone House to fund a Parent/Child Nurturing Center for abused women and children. The same plan offers childhood education workshops and home visits for medically-underserved and low-income families in the inner city. Recognizing that homeless and low- income children are at high risk for developmental delays, a health plan that operates in the Worcester area supports an early-childhood intervention program designed to focus on the critical developmental needs of these children.

2. Community Education

The second most frequently-reported category is Community Education. HMOs reported on 123 projects (around 24 percent of the total) that relate primarily to health education.

Many HMOs have formed partnerships with neighborhood schools to promote health education. A western-Massachusetts HMO has developed a program to teach parents and children how to manage asthma more effectively and to enhance the psychological and physical health of children with respiratory diseases. An HMO serving the city of Worcester introduced a "Home Alone Program" for elementary school children to increase their awareness of personal safety issues. It also supports a training program that teaches sixth graders how to deal constructively with peer pressure.

A greater-Boston HMO has worked closely with inner-city high school students to provide support for the transition from school to work and to improve job readiness. Another plan has worked closely with area schools to offer students the opportunity to explore careers in nursing and medicine through field work in health-care settings.

Several HMOs support projects designed to address a variety of family issues. One teaches parenting skills to new mothers. A greater-Boston HMO conducted a public-awareness and education campaign on the relationship between health and learning in younger children. An HMO serving southeastern Massachusetts conducted a forum designed to increase public awareness about domestic violence and to provide information on resources available to abused women and children. Another plan works with local organizations to provide information and support for family members caring for Alzheimer patients.

Several HMOs have introduced programs designed to increase community awareness of HIV and to raise funds for outreach agencies. One such program supports a medical van that delivers health care to high-risk street populations for the purpose of preventing the spread of HIV and other sexually-transmitted diseases. It also targets residents of Chinatown by offering bilingual and culturally-sensitive programs on health education and disease prevention.

3. Volunteerism

Seventy-five Community Benefits efforts (around 14 percent of the total) fall within the category of volunteerism. "Volunteerism" refers to contributions of HMO employees' time or money in the public service. Reportable volunteer efforts of HMO employees are limited to those that either have taken place during the work hours of the employee volunteers, or have resulted from the HMOs' concerted efforts to encourage, organize or facilitate volunteerism by their employees.

Because of unclear reporting in some instances, we are not able to confirm that all of the HMOs' reported volunteerism efforts satisfy this definition. Furthermore, the majority of the reported volunteer endeavors had no direct connection to any formal Community Benefits Program. In the future, this type of volunteerism will be placed in a new "Community Service" category along with other "good works" that are not part of formal Programs (see below).

Some examples of this year's reported volunteer activities are as follows. Many HMOs encouraged their employees to take part in annual walks to raise money for programs that target hunger, AIDS, and breast cancer, or to participate in fundraising activities for the Jimmy Fund and the Dana Farber Cancer Institute. Others promoted their employees' participation in clothing and food drives for local shelters and in the distribution of holiday gifts to needy children. One HMO sponsored a campaign that raised money from its employees to help seriously-ill children fulfill their final wishes.

One HMO enlisted employee volunteers to conduct a month-long campaign to enroll eligible children in the state's Children's Medical Security Plan. Another formed a partnership with an inner-city hospital to create an "Alliance for the Homeless" in which HMO employees volunteer to provide medical and educational support to unemployed and homeless individuals. Finally, a central-Massachusetts HMO used employee volunteers to conduct mammography screening for uninsured and underinsured women.

4. Health Screening

HMOs reported on 56 Community Benefits projects (around 11 percent of the total) that provide health-screening services for a variety of health conditions. Many HMOs offered these services through plan-sponsored health fairs. For instance, an HMO in southeastern Massachusetts conducted "A Wellness Exposition" which offered health screening and information on a variety of health issues to over 1,000 attendees. Another HMO, in partnership with a community arts council, conducted a combined health fair and art festival that provided eye exams, cholesterol screening and health assessments for 2,000 participants.

Several HMOs reached out to underserved non-English speaking populations by employing bilingual staff and disseminating public health information in several languages. HMOs participated in an "August Moon Festival" to provide preventive health information to members of the Asian community, a Haitian health festival to provide cholesterol screening to 300 participants, and a health fair in central Massachusetts to promote fitness and healthy lifestyles to the Latino community.

5. Information Access

Thirty-five of the Community Benefits projects on which the HMOs reported (around 7 percent of the total) provided "information access" to the community. This category includes such initiatives as the use of television, radio and other media to widely disseminate information about health care issues, and the operation of telephone hotlines and speakers bureaus. There is considerable overlap between the information access and community education categories. Information access Community Benefits projects include production of public service announcements on certain health issues and provider participation in television interviews. An HMO in southeastern Massachusetts produced a series of educational programs on women's health. Another HMO organized a health care forum that brought together public policy leaders and providers to focus on issues facing medically-underserved women. The forum resulted in the production of a domestic violence safety plan for emergency rooms, physician offices, shelters, and law enforcement agencies.

One HMO established a Senior Resource Line that links callers to services and community programs. Another instituted a confidential HIV/AIDS hotline that handled over six thousand calls in 1996. Several HMOs created speakers bureaus from which schools and community groups can connect with experts to address them on matters of health and lifestyles.

6. Direct Care

The HMOs reported on 14 Community Benefits projects (less than 3 percent of the total) that fall into the direct care category. A single HMO was responsible for over three quarters of the programs in this category. The most common direct care programs are those that provide immunizations. Other initiatives include the delivery of primary care to high-risk adolescents in an inner-city high school, the provision of health care services to the homeless, and the conducting of physical examinations of low-income children to enable them to participate in a national sports program.

7. Health Insurance

Four HMOs are responsible for the seven Community Benefits initiatives (just over one percent of the total) that provide or increase access to health coverage to the uninsured. One HMO offers more-affordable medical coverage for children through a product that allows uninsured families to purchase health coverage for their children only. Another HMO provided coverage to thirty uninsured teens in connection with their participation in a volunteer program. Two HMOs offer some assistance to low-income plan members whose continued coverage is threatened when they become unemployed. The most substantial program is a "dues subsidy plan" through which one HMO provided almost $400,000 in dues assistance for low-income members of its non-group plan, many of whom were previously uninsured.

IV. COMMENTARY

A. Status of Community Benefits Programs as Reflected in the Annual Reports.

The Annual Reports reflect a reasonable first effort of many HMOs to institutionalize the concept of Community Benefits within their organizational structures. They also highlight the vast differences between individual HMOs in terms of the stages of development of their Community Benefits Programs, the levels of financial commitment to their Programs, and the quality of their program implementation, evaluation and reporting.

Any commentary should take into account the fact that this was the HMOs' initial attempt to report on what is the nation's only HMO Community Benefits initiative. Although the HMO Community Benefits Guidelines were modeled after the earlier-established Hospital Community Benefits Guidelines, there are limits to what HMOs can draw from the experience of hospitals. Unlike hospitals, HMOs have few natural constituencies within communities because they tend to serve wider geographic areas. Furthermore, HMOs are not typically in the business of providing direct health care services. These differences will influence the directions in which the HMO and hospital Community Benefits Programs develop.

It is premature to draw general conclusions about the collective strengths and weaknesses of the HMOs' Community Benefits Programs thus far. The HMOs' performances vary widely under almost all of the nine Guidelines. Some HMOs demonstrate great strength when it comes to community participation and needs assessment, for instance, while others show much room for improvement.

There are, however, some general comments and observations that we can make at this point. First, the most significant achievement of the first year of the Guidelines might be that some HMOs that previously had no formal, institutionalized commitment to Community Benefits have laid the groundwork for solid Programs. Several HMOs appear to have established well-designed processes for their Community Benefits Programs. Although many of the actual Programs are still in the initial implementation phases, some of these could prove quite effective over time. The ultimate success of these Programs will depend on how well the HMOs build on their foundations by following through on the processes that they have established and by committing resources.

One area of significant concern is the lack of connection we often observed between the HMOs' needs assessment results and the target populations that they have identified, or between these target populations and the type of Community Benefits projects that they have chosen to pursue. Of related concern are instances where we detected apparent conformity to the letter but not the spirit of the Guidelines. It never was among the intentions of the Guidelines to elevate form over substance. A plan might have an eloquent Policy Statement, but this is no substitute for a well-designed, adequately-funded Program. Our expectation is that in future years HMOs will devote sufficient resources to achieve their stated Program objectives, and that they will do a better job of targeting those resources toward the goals they have identified.

It also is important that most of the HMOs improve their compliance with the community participation element of the Guidelines. The Guidelines anticipate that the HMOs will obtain community input on most aspects of their Community Benefits Programs. These include the needs assessment and priority-setting processes, Program design and Program evaluation. The meaningful involvement of the community would go a long way toward promoting a clear connection between needs assessment results, selected target populations and actual projects and initiatives. This, in turn, would ensure that Community Benefit Programs focus on the real needs of communities.

Several HMOs made plan members and other populations that typically do not fall within the category of "medically-underserved" the primary beneficiaries of their Community Benefits Programs. Although the Guidelines clearly recognize the value of and support Programs that promote the health and well-being of current HMO members, we do not consider HMOs whose Programs predominantly serve their own members to be operating within the spirit of the Guidelines. Specifically, an HMO does not satisfy the Guidelines when it repackages member services or quality assurance programs as Community Benefits, has no Program that extends to at least some non-members, and does nothing else to address the needs of underserved populations.

The standard grid format on which the HMOs have detailed their specific Community Benefits projects has proved useful to our analysis. It has helped us to evaluate the areas in which each HMO is focusing its efforts, the consistency of this focus with its Policy Statement, and its level of commitment toward its Programs. This objective format provides the clearest indication of how much substance there is to a particular Community Benefits Program. We appreciate the effort on the part of the HMOs that goes into completing the grids. We further believe that this exercise is worthwhile not only for the purposes of our analysis but for the HMOs' own internal discussions and self-evaluations. We will address the remaining lack of uniformity in reporting by further definition and revision of the grid (see below).

Finally, we recognize that a significant element in the successful implementation of the HMO Community Benefits Guidelines during the past year has been the ongoing dialogue that the Attorney General's Office has had with representatives of the HMOs, MAHMO and community groups. These positive, cooperative working relationships helped us to answer questions and resolve issues as they surfaced throughout the year, and will be of continued assistance as we work toward refining the Community Benefits initiative in the future.

B. Recommended Refinements of Reporting Process and Format, and Guideline Interpretation.

Because the 1996-1997 Annual Reports represent the first attempt by HMOs to report on their Community Benefits efforts, we anticipated that there would be a need for some clarification both in the reporting format and in the interpretation of the Guidelines. We believe that such fine tuning and reassessment is, and will continue to be, a valuable component of the development process for Community Benefits Programs.

The first issue concerns the fundamental question of what is a Community Benefit. In this initial round of reporting, many HMOs included philanthropic efforts as part of their Community Benefits Programs. These efforts, such as donations to charitable funds and sponsorships of cultural events, are certainly positive examples of good corporate citizenship that deserve praise. Some of these charitable contributions in fact were directed at causes that are health-related, or went to programs that serve the HMOs' identified target populations.

Many of these contributions, however, were not even indirectly related to any formal Community Benefits Program or did not have any tangible connection to the improvement of health status. Although these philanthropic activities and other instances of good corporate citizenship do not satisfy the definition of "Community Benefits," we do not want to discount or discourage them. We believe that a satisfactory solution lies in the creation of a new category on the reporting grid entitled "Community Service." Under this new category, HMOs will be able to report any charitable activities that are not connected with their formal Community Benefits Programs. These would not be limited to donations of money, but would include any other activity (e.g., volunteerism, education, direct services) that is not reasonably related to the HMOs' formal Community Benefits Programs. By the same token, HMOs that make charitable donations that have a clear relationship with a formal Program will be free to report these under the appropriate Community Benefits category. This mirrors the approach of the Hospital Community Benefits Guidelines.

To address the problem of unclear or incomplete reporting on the grids by a few HMOs, we will exclude non-itemized entries in the future. HMOs that report donations and grants, for example, must list the exact amounts and identify the organizations to which they donated the funds. The mere statement of a grand total will not suffice. Likewise, national HMOs must make an effort to isolate Community Benefit Programs that are targeted toward Massachusetts residents from Programs that will not benefit communities within Massachusetts. If an HMO operates a coordinated volunteer campaign, furthermore, it will not be acceptable for it to report volunteer hours as one lump sum; rather, it must break these down into categories that allow third parties to ascertain the nature of these activities and whether they truly meet the definition of Community Benefits. The category of volunteerism is one that is in particular need of refinement to ensure uniformity in reporting among HMOs. This issue will be the focus of further discussion during the next year.

Another area in need of clarification concerns the inclusion of medical research and training as Community Benefits. The Hospital Community Benefits Guidelines make it clear that medical research and training do not qualify as Community Benefits in the hospital context because these activities constitute a central function of many hospitals, and it would be difficult to isolate research and development into a Community Benefits Program serving underserved populations. Medical research and training, however, are not traditionally within the realm of HMOs. In order to encourage HMOs to engage in innovative research and training activities that are aimed at benefiting underserved populations, we will count such activities as Community Benefits as long as they are part of an HMO's formal Community Benefits Program.

Two items that stand out as not meeting the definition of Community Benefits are Medicaid shortfalls and taxes paid by for-profit HMOs. The goal of the Community Benefits Guidelines is to encourage HMOs to develop well-designed, coordinated and targeted Community Benefits Programs that are based upon formal assessments of public health needs and include community participation. Although we understand the rationales of the HMOs that did report taxes and Medicaid shortfalls as Community Benefits in their first Annual Reports, it is our position that these expenditures do not fit the above criteria in any way. This is consistent with the treatment of Medicaid shortfalls under the Hospital Guidelines.

There was some confusion as to the amount that an HMO should claim as a Community Benefits expenditure if it has obtained a grant from a third party that it uses to operate a Community Benefits Program. Because the HMO's efforts to obtain the grant were essential to making the funds available for Community Benefits in Massachusetts, we believe that it is appropriate for the HMO to report the entire amount of the grant, rather than just the administrative costs in obtaining it, provided that the funded project is part of the HMO's formal Community Benefits Program. Again, this is consistent with the treatment of grant receipts under the Hospital Guidelines.

Finally, several HMOs reported on Community Benefits Programs that are accessible only to their current members. In our view, the reporting of such programs is appropriate only if they target medically-underserved populations within their memberships and are part of a formal Community Benefits Program. Although these will be counted as programs, HMOs should not claim any of the associated costs unless they can make a compelling argument that the funds did not come from member dues. This does indeed reflect the approaches to members-only services that most HMOs described in this year's Annual Reports.

C. Community Benefits Guideline Goals for 1997-1998

We anticipate that during the next year HMOs will continue to build upon the initial efforts they have devoted to their Community Benefits Programs. Many HMOs previously did not have in place formal Community Benefits Programs, and therefore spent most of the past year laying the groundwork. Some HMOs still have more work to do in this area, while others now seem well-positioned to move ahead into the implementation phase if they have not done so already. We would encourage HMOs to pay particular attention to the critical areas of needs assessment, processes for program evaluation and community participation. As previously discussed, the success of any Community Benefits Program depends upon the existence of these elements.

With respect to the further development of the Guidelines themselves, the primary objectives for the following year are: (1) to further refine the reporting process to make the Annual Reports a more reliable and informative indicator of the HMOs' progress on their Community Benefits Programs; (2) to develop measures to assess the level of the HMOs' financial commitment to their Community Benefits Programs, and the effectiveness of these Programs; (3) to organize a technical support meeting for the Community Benefits coordinators and other HMO leadership to assist HMOs as they move forward on their

Programs; and (4) to consider innovative ways in which HMOs can partner with each other and with hospitals and other providers to coordinate delivery of Community Benefits in the future.

Given that the next Annual Reports are due in less than six months from now, it might be overly ambitious to expect that we can achieve all of these goals before then. Because the working relationship of the Attorney General's Office and the HMOs and their representatives on Community Benefits has been one of cooperation and partnership, however, we believe that we will be able to make reasonable progress.

V. CONCLUSION

The HMOs' first Annual Community Benefits Reports paint a picture of a progressive initiative that is off to a good start, and has the potential to contribute to substantial improvements in the health status of Massachusetts communities. Although many Community Benefits Programs still have a long way to go before they start producing such results, we should not fail to recognize both the willingness of all Massachusetts HMOs to participate under the Community Benefits Guidelines and the progress that some HMOs have made toward developing Programs that show tremendous promise. We urge all HMOs to refocus their efforts to achieve meaningful community participation in their Programs and to enhance their needs assessment and Program evaluation processes. We remain confident that the HMOs' future accomplishments in these areas, together with increased levels of financial commitment, will yield Programs that provide important health benefits to those Massachusetts residents who are most in need.

ENDNOTES

[1] In 1996, Healthy Communities Massachusetts Network convened the Citizens' Advisory Board on the Attorney General's Community Benefits Guidelines. The purpose of the Advisory Board is to provide information to the Attorney General on implementation issues related to both the Hospital and HMO Guidelines. Its members include representatives of a broad base of consumer, legal and health advocacy groups from around Massachusetts, health care providers, the HMO industry and the Department of Public Health.

[2] It is difficult to determine what percentage of the HMOs' total Massachusetts revenues this $6.8 million represents. The information maintained by HMOs that operate on a regional or national level often is not broken down in a way from which it is possible to determine Massachusetts revenues. It also is not clear that the percentage of Community Benefits expenditures out of total revenues is the best measure of the HMOs' commitment to Community Benefits. One goal for the coming year is to develop appropriate measures for use in future reporting years.

LOCATIONS FOR VIEWING COPIES OF THE ANNUAL COMMUNITY BENEFITS REPORTS FILED BY HMOs

I. MASSACHUSETTS PREVENTION CENTERS:

WESTERN MASSACHUSETTS

Lower Pioneer Valley/Springfield Area
Massachusetts Prevention Center
110 Maple Street, Suite 301
Springfield, MA 01104
(413) 732-2009
Amina Ali, Director

Hampshire, Franklin, & Berkshire Counties
Massachusetts Prevention Center
76 Pleasant Street
Northampton, MA 01060
(413) 584-3880 or (800)-850-3880
Jeff Harness, Director

CENTRAL MASSACHUSETTS

Greater Framingham/South Central
Massachusetts Prevention Center
158 Union Avenue
Framingham, MA 01701
(508) 875-5419
Susan P. Downey, Director

Greater Worcester/North Central
531 Main Street
Worcester, MA 01608
(508) 752-8083 or (800) 752-8083
Kristen Nicholas, Director

NORTHEASTERN MASSACHUSETTS

Merrimack Valley/Lowell & Lawrence
Massachusetts Prevention Center
One South Union Street
Lawrence, MA 01840
(508) 688-2323 or (800) LIVEWELL
Zoraida Lebron, Director

West Suburban/North Shore
Massachusetts Prevention Center
27 Congress Street
Salem, MA 01970
(508) 745-8890 or (800) 334-5512
Carol Oliver, Director

GREATER BOSTON

City of Boston
Massachusetts Prevention Center
95 Berkeley Street
Boston, MA 02116
(617) 451-0049
Margaret Henderson, Director

Boston Suburbs
Massachusetts Prevention Center
552 Massachusetts Avenue, Suite 203
Cambridge, MA 02139
(617) 441-0700
Marsha Lazar, Director

LOCATIONS FOR VIEWING COPIES OF THE ANNUAL COMMUNITY BENEFITS REPORTS FILED BY HMOs

SOUTHEASTERN MASSACHUSETTS

Brockton/Plymouth/South Shore
Massachusetts Prevention Center
942 West Chestnut Street
Brockton, MA 02401
(508) 583-2350
Randy Yates, Director

Fall River/New Bedford/Cape
Massachusetts Prevention Center
105 William Street
New Bedford, MA 02740
(508) 996-3147
Warren Berube, Director

Note: The individual HMOs have copies of their own reports available for viewing. See Appendix E for Community Benefits contact persons at the HMOs.

II. OTHER LOCATIONS:

Office of the Attorney General
Law Library, 20th Floor
One Ashburton Place
Boston, MA 02108
(617) 727-2200

Office of the Attorney General
Western Massachusetts Office
436 Dwight Street
Springfield, MA 01103
(413) 784-1240

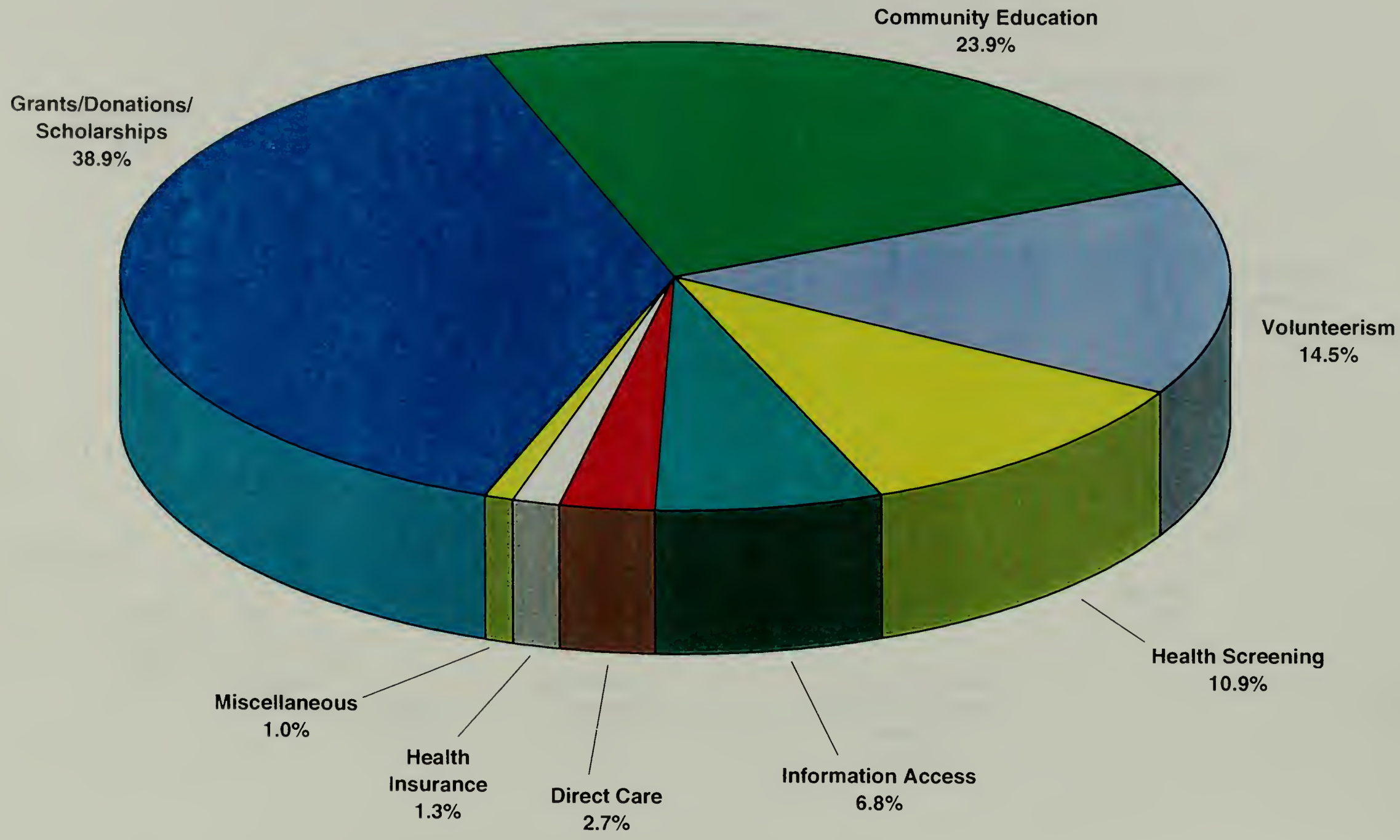
Massachusetts Association of HMOs
18 Tremont Street
Boston, MA 02108
(617) 523-3300

HMO NAME: Your Community Health Plan
No. Of HMO Members: 110,000
As Of: July 1, 1996 - June 30, 1997

Category	Program Name Administrator Title Phone # Total # Staff	Target Population # Served Program Area	Program Goal Time Frame	Community Contact Organization Phone # Total # Participants	Assessment Performed? Identified Needs Data/Info Source	Outcomes	Total Spent/Prog($) Cash ($) Grants ($) In Kind ($)	Admin Costs ($)
Direct Care	"Free Flu Shots" Jane Doe Nursing Supervisor 617-123-4567 3	Haitian Immigrants 500 Cambridge, Somerville	Prevent flu Sept, Oct, Nov '96	Pierre Michel Haitian Social Club 617-234-5678 25	Yes Flu prevention DPH, Haitian Church Council	95% did not get flu	10,000 10,000 0 0	8,000 00
Education	"Let's Talk" Janine Fox Director Patient Education 508-777-9898 8	Battered Elders 1,000 Cape Cod	Prevent elder abuse Jan - June '97	Arlene Geft CCSAC 508-771-1200 15	Yes Prevent elder abuse DPH, Cape Cod Seniors	Elder abuse reduced 25%. 100% educated on prevention tactics.	25,000 15,000 5,000 5,000	13,000
Grant-Making								
Volunteerism								
Health Insurance								
Information Access								
Screening								
TOTALS							**35,000 25,000 5,000 5,000**	**21,000**

Community Benefits by HMOs in 1996-1997

Program Categories *

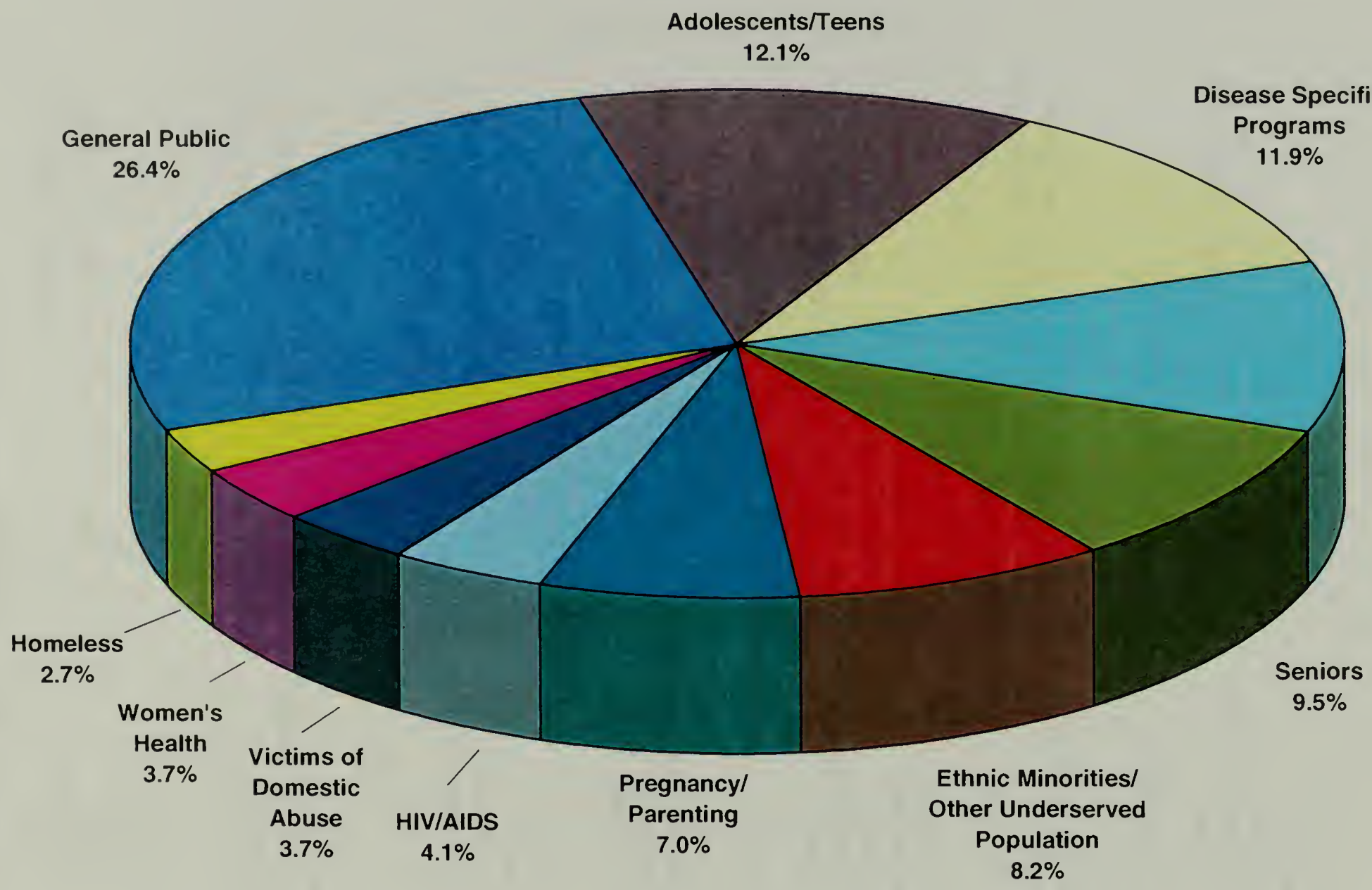


* Based Upon the Attorney General's Analysis of the HMOs' Annual Community Benefits Reports for 1996-1997

APPENDIX C

Community Benefits by HMOs in 1996-1997

Target Populations *



* Based Upon the Attorney General's Analysis of the HMOs' Annual Community Benefits Reports for 1996-1997

Community Benefits Contacts List

Mr. Colin E. McCarthy
Director, Provider Relations
Aetna U.S. Healthcare
3 Burlington Woods Drive
Burlington, MA 01803

Phone (800) 624-0756
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